MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Wol + Med, Ed. Wolski, M.D., G. Eubanks, ORT, R. Helstem, MD 2436 IH-35 East South, Ste. 336 Denton TX 75205	MDR Tracking No.: M4-03-A043-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 47 American Casualty Co. /Gallagher Bassett PO Box 23812 Tuson AZ 85734	Date of Injury: Employer's Name: Thyssenkrupp Elevator Corp. Insurance Carrier's No.: 011508010245WC01

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/8/02	10/10/02	97139-PH	$0.00	Duplicate DOS $0.00
10/11/02	10/11/02	97750	$344.00	$0.00
10/24/02	11/5/02	97139-PH	$30.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

8/27/03: "…The carrier has failed to make proper reimbursement for our charges…Our position…1)…carrier failed to make adequate reimbursement…denying payment with a substandard EOB…2) The carrier has also failed to make reimbursement according to TWCC Rules…to "develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar reimbursement", as the carrier has made different reimbursements for this same procedure on this patient…"

PART IV: RESPONDENT'S POSITION SUMMARY

NO RESPONSE RECEIVED FROM RESPONDENT

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT code 97750: DOS 10/11/02, was denied by the respondent, "91001 S Typically Provided on a Single Date of Service." According to 133.304 (c), the respondent did not provide sufficient explanation to allow the sender to understand the reason for the reduction or denial of payment. The CPT descriptor for 97750 includes testing and measurement with a written report. The provider did not submit documentation to substantiate criteria for reimbursement according to 133.1 (a)(8), therefore reimbursement can not be recommended.
- CPT code 97139-PH: DOS 10/8/02 and 10/10/02 are duplicate submission received and reviewed in another MDR dispute, therefore these DOS will not me mentioned further in this Finding and Decision. DOS 10/24/02 – 11/5/02 were denied with the statement, "TED According to state fee schedule guidelines." Due to the MFG descriptor for this CPT code indicating payment is DOP, the denial by the respondent is incorrectly denied. The requestor submitted SOAP notes to substantiate services rendered, but did not provide criteria for billing of usual and customary rates, therefore additional reimbursement can not be recommended.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Ordered by:

		4/15/05
Authorized Signature	Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____